SANMARCOS

2018

Benefits Enrollment Guide

This guide highlights the main features of many of the benefit plans sponsored by the City of San Marcos. Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. The City of San Marcos reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time.

Contents

IMPORTANT: If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, the Medicare Prescription Drug program gives you more choices about your prescription drug coverage. Please see pages 30 – 31 for more details.

OPEN ENROLLMENT

2018 Open Enrollment (October 16, 2017– November 9, 2017)

Welcome to the 2018 City of San Marcos Open Enrollment. The City of San Marcos provides an open enrollment period for employees to review their benefits and to make new elections for the upcoming year. This year's open enrollment will be held from October 16 through November 9, 2017. Everyone is required to elect their 2018 benefits online by November 9, 2017.

New Employee Enrollment

New employees will enroll during their Benefit Orientation. Benefits are effective the first of the month following 30 days of employment. Dependent verification documentation will be required for all covered dependents.

Online Enrollment Process

All benefit elections must be made in the online system at https://uhc.workterra.net. Employees can enroll using the following credentials:

USER NAME: First Name Initial, Last Name and Last 4 of your SSN
PASSWORD: First 5 of your SSN
COMPANY: City of San Marcos

Your 2018 Benefits Guide has been designed to help you understand all the options available to you, so that you can make the best possible benefit decisions for yourself and your family. This guide provides an overview of terms and conditions of the insurance and wellness programs for the City of San Marcos employees.

OUR BENEFITS PROGRAM HAS YOU COVERED

Most days, we all count on our simple routines to get us through. Getting the kids to school, beating the traffic to work, and finishing dinner in time to enjoy a favorite hobby. However, sometimes things do not always go as planned. Like when your head cold turns into the flu and you have to be out of work. Or your son's football game ends with a broken leg. Or even when your spouse learns he or she needs an extensive root canal. That's when the City of San Marcos' benefits are there to help you.

BENEFITS OVERVIEW

Below is an overview of our benefits program, which gives you the coverage you need for all types of things life brings your way. The City of San Marcos' benefit plans allow you to choose the options that work best for your own needs — and your pocketbook. The key to getting the most from our benefits program is to take an active role in understanding and using the plans so that you are getting the best value for the money you spend.

Benefits Provided at No Cost to You	Benefits You Pay For
Basic life Insurance	Medical and Prescription Drug
Basic AD&D Insurance	Dental Plan
Employee Assistance Program	Vision Plan
	Supplemental Life Insurance
	Optional AD&D Insurance
	Long-Term Disability
	Flexible Spending Accounts

You are eligible to enroll in the City of San Marcos' benefit plans if you are a regular, full-time employee scheduled to work at least 30 hours per week. As a regular, full-time employee, you are eligible for benefits on the first day of the month following 30 days of continuous service.

DEPENDENT ELIGIBILITY

You may also cover your eligible dependents, including:

- Your legal spouse.
- Your eligible children up to age 26 for medical coverage; your unmarried, eligible children up to age 26 for dental and vision coverage.
- "Children" are defined as your natural children, stepchildren, legally adopted children, and children for whom you are the court-appointed legal guardian.
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.

If your child becomes ineligible for coverage (i.e., turning age 26 under the medical plan), you must notify the Human Resources Department at 512-393-8060 or benefits@sanmarcosstx.gov.

RETIREE and RETIREE DEPENDENT ELIGIBILITY

You are eligible to enroll in the City of San Marcos' benefit plans if:

- You are entitled to receive retirement benefits from the Texas Municipal Retirement System.
- You are currently covered under the medical, dental or vision plan as an active employee.
- You may also cover your eligible dependents as long as they are on the plans at the time of your retirement.
- If your dependent spouse is also a City of San Marcos retiree and has had continuous coverage, they can continue this policy as a single retiree.

For a more complete list of eligibility requirements for Retirees, refer to the Summary Plan Description.

If your child becomes ineligible for coverage (i.e., turning age 26 under the medical plan), you must notify the Human Resources Department at 512-393-8060 or benefits@sanmarcosstx.gov.

INITIAL ENROLLMENT

When you first join the City of San Marcos, you have 31 days to enroll yourself and your dependents for benefits. If you enroll on time, coverage begins the first of the month following 30 days of employment. If you do not enroll within 31 days of becoming eligible, you will automatically be enrolled in company-sponsored benefits, such as Basic Life and Accidental Death & Dismemberment (AD&D) Insurance and the Employee Assistance Program (EAP), but you will have to wait until the next annual Open Enrollment to enroll for other benefits and make changes to coverage.

ANNUAL OPEN ENROLLMENT

During annual Open Enrollment, coverage takes effect on January 1 of the following year.

MAKING CHANGES TO COVERAGE

Once you make your benefit elections, these choices remain in effect until the next annual Open Enrollment unless you have a qualified status change or you or your eligible dependents become eligible for coverage through special enrollment rules.

If you have a qualified status change or you have another allowable event, you can make certain changes during the plan year. However, you must make your enrollment change within 31 days of the event. Contact Human Resources for enrollment assistance and dependent verification. If you do not enroll within 31 days, you will have to wait until the next Open Enrollment to make new elections.

Qualified status changes include, but are not limited to:

- Change in number of eligible dependents due to birth, adoption, placement for adoption, or death
- Gain or loss of dependent status (i.e., your child reaches the age limit for eligibility)
- Change in legal marital status, including marriage, divorce, or death of a spouse
- Change in residence or workplace that changes your or your dependent's eligibility for coverage
- Change in employment status, such as starting or ending employment, for you, your spouse, or your children
- End of the maximum period for COBRA coverage

For a more complete list of qualified status changes, refer to the Summary Plan Description.

SPECIAL ENROLLMENT RULES

If you choose not to enroll yourself or your dependents (including your spouse) because you have other coverage, you may be able to enroll yourself and your dependents at a later date if:

- You or your dependents lose Medicaid or Children's Health Insurance Program ("CHIP") coverage as a result of a loss of eligibility for such coverage, or
- If you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You must enroll within 60 days of the qualified events shown in the "Special Enrollment Rules" above.

If your dependent also had other health coverage and lost that coverage in the above situations, they may be added to your coverage. However, you will not be able to add yourself or your dependents to this coverage if the other coverage was terminated "for cause" (including failure to pay the required premiums on time).

In addition to the changes described previously, you may enroll yourself and your spouse in a City of San Marcos' health plan following marriage or adoption, placement for adoption, or birth of a child, as long as you request enrollment within 31 days of the event. You must be enrolled to cover your dependents. If you have a special enrollment event and want to enroll for health coverage, call Human Resources at 512-393-8060 or benefits@sanmarcostx.gov.

CITY OF SAN MARCOS MEDICAL PLAN

The City of San Marcos' medical plan provides coverage for the same types of expenses, such as doctor's office visits, preventive care, prescription drugs, and hospitalization.

When it comes to medical coverage, the City of San Marcos offers you a PPO Plan administered by United Healthcare.

Preferred Provider Organizations (PPO)

The PPO plans offer in-network and out-of-network benefits. When you need care, you decide whether to go to an in-network or an out-of-network provider. If you receive care from in-network doctors and facilities, your out-of-pocket costs will be lower than if you use out-of-network providers and facilities because network providers discount their fees. And, with in-network providers, you generally do not have to file claims.

All of the providers in the UHC network change frequently. To find out if your doctor participates in the network, go to www.myuhc.com or 844-269-5757.

If you choose to receive care from an out-of-network provider, the medical plan pays a lower benefit and you must file a claim to receive reimbursement for covered expenses.

MEDICAL PLAN COMPARISON

	PPO Plan	
	In-Network	**Out-of-Network**
Individual Deductible	$1,000	$2,000
Family Deductible	$2,000	$4,000
Individual Out-of-Pocket Maximum	$3,000	$4,500
Family Out-of-Pocket Maximum	$6,000	$9,000
Prescription Drug Deductible	$100 per person	$100 per person
Prescription Drug Individual Out-of-Pocket Maximum	$3,000	$3,000
Prescription Drug Family Out-of-Pocket Maximum	$6,000	$6,000
Preventive Care	No Charge	Not Covered
Primary Care Physician	$30 copay	50% after deductible
Specialist	$50 copay	50% after deductible
Diagnostics, X-Ray, and Lab Services	20% after deductible	50% after deductible
Lab Services provided at LabCorp or CPL	No Charge	50% after deductible
Urgent Care	$50 copay	50% after deductible
Emergency Room	$250 copay	$250 copay
Inpatient Hospital Care	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Virtual Visits	$15 copay	Not Covered

PRESCRIPTION DRUG COVERAGE

If you enroll in the City of San Marcos medical plan, you will automatically receive prescription drug coverage provided through UHC Optum. When you need prescriptions, you can purchase them through a local retail pharmacy or, for medications you take on an ongoing basis, through the mail order program.

Retail Prescription Program

The retail prescription program uses a network of participating pharmacies. To receive the highest level of benefits, you must use a participating pharmacy. Prescriptions you fill at non-participating pharmacies are generally not covered.

Mail Order Program

The mail order program offers a convenient and cost-effective way to fill prescriptions for medications you take on a regular basis (maintenance medications). When you use the mail order program, you receive a 90-day supply of medication for the cost of a 2 ½ month supply. Your medications are mailed directly to your home. To order prescriptions through the mail order program, you must fill out a mail order form and return it with a 90-day prescription from your doctor and your payment. Mail order forms are available from your HR Department or on the UHC Optum website at myuhc.com.

Specialty Prescription Program

If you have a chronic condition and take specialty medications, you must purchase these through a designated specialty pharmacy that provides the best available pricing and additional support. If you have a prescription that meets this requirement, UHC will contact you and provide you with the necessary information to fill your prescription.

Prescription Drug Plan Highlights

		PPO Plan	
		In-Network	**Out-of-Network**
Tier 1	Up to 34 Day Supply 35 to 90 Day Supply	$5 copay $12.50 copay	$5 copay $12.50 copay
Tier 2	Retail Mail Order	$30 $75	$30 Not Covered
Tier 3	Retail Mail Order	$75 $187.50	$75 Not Covered
Tier 4 – Specialty Drugs	Mail Order – Up to 31 Day Supply	$100	Not Covered

UHC offers several tools to help you and your dependents navigate through your medical needs.

Get quick doctor care
from anywhere.

amwell.com

doctorondemand.com
Note: Doctor on Demand does not support any version of Internet Explorer®.

A Virtual Visit lets you see talk with a doctor from your laptop or mobile device.

You have access to a network of Virtual Visit provider groups. To learn more about Virtual Visits and our network please log into **myuhc.com®** or the UnitedHealthcare **Health4Me®** app.

Once you choose a Virtual Visit provider group you'll be directed to their website from **myuhc.com** or their app from Health4Me. You also have the option of going directly to their website or app to access care. You can download their app directly from **Google Play™** or the **Apple® App Store®**.

Virtual Visits are covered under your health plan benefits either way you decide to access care.

Download on the App Store | GET IT ON Google play

Apple and App Store are registered trademarks of Apple, Inc. Google Play is a trademark of Google, Inc.

Access to Virtual Visits and prescription services may not be available in all states or for all groups. Go to myuhc.com for more information about availability of Virtual Visits and prescription services. Always refer to your plan documents for your specific coverage. Virtual Visits are not an insurance product; health care provider or a health plan. Virtual Visits are an Internet-based service provided by contracted UnitedHealthcare providers that allow members to select and interact with independent physicians and other health care providers. It is the member's responsibility to select health care professionals. Care decisions are between the consumer and physician. Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times or in all locations. Members have cost share responsibility and all claims are adjudicated according to the terms of the member's benefits plan. Payment for Virtual Visit services does not cover pharmacy charges; members must pay for prescriptions (if any) separately. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

Tips for registering:

Locate your member ID number on your health plan ID card

Or look up your number on **myuhc.com**.

Have your primary care provider name and medical history ready.

Choose a pharmacy that's open in case you're given a prescription.

UnitedHealthcare

Health care resources in your hands.

Health4Me is designed to make managing health care a lot simpler. You can easily access your health plan ID card, benefit amounts, account balances and Personal Health Records. You can manage claims, estimate costs, search drug pricing and find nearby providers and quick care facilities anytime and anywhere. Health4Me allows you to personalize the interface, pay a doctor's bill and even talk to someone at the push of a button if you have questions.

Estimate costs and see quality and cost-efficiency ratings

With the myHealthcare Cost Estimator tool on Health4Me, you can estimate out-of-pocket costs up front. By simply entering a procedure or condition, you can see how estimated costs can differ from provider to provider and facility to facility. You will even see which providers have UnitedHealth Premium® designations for meeting quality and cost-efficiency measures. Understanding the cost and quality ratings may help you make more informed health care decisions.

Personal care.

And if you can't find the answer you're looking for, the app can connect you with a helpful professional through Easy Connect. The Easy Connect feature asks you what you need help with, then has an Advocate contact you with the appropriate information. And NurseLine℠ can put you in touch with a caring nurse 24 hours a day, seven days a week.

Built to grow.

Health4Me is designed to simplify and streamline access to your health care resources in a secure and convenient way. It's a platform that is built to grow and help you and your family lead healthier lives today.

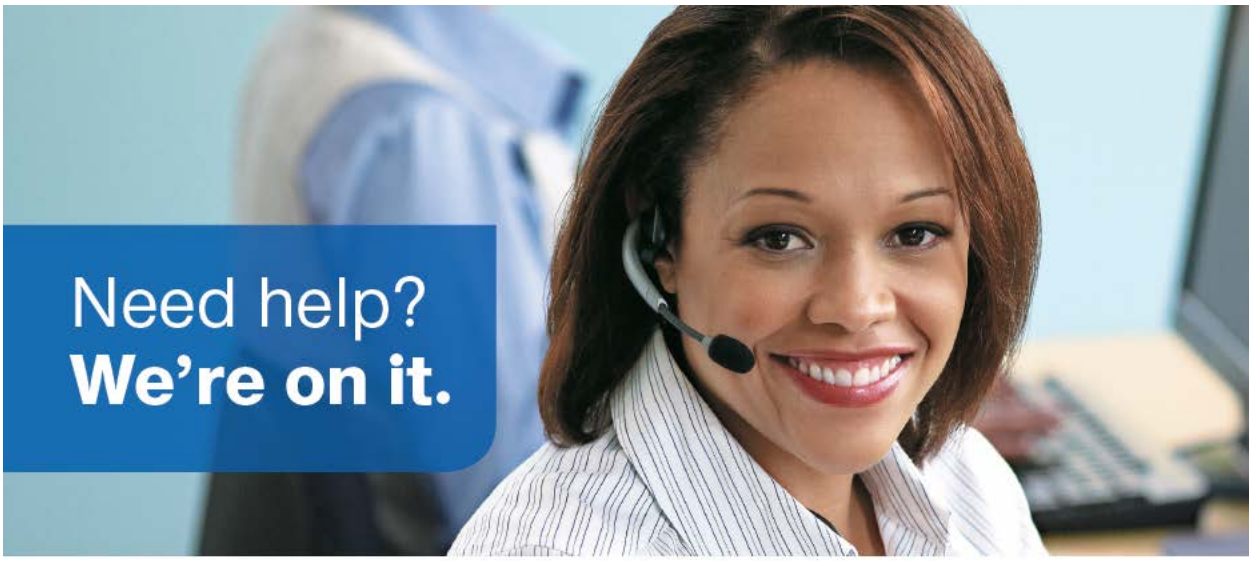
Health4Me

Download on the App Store

Android available in Google play

All UnitedHealthcare members can access a cost estimator online tool at myuhc.com. Depending on your specific benefit plan and the ZIP code that is entered, either the myHealthcare Cost Estimator or the Treatment Cost Estimator will be available. A mobile version of myHealthcare Cost Estimator is available in the Health4Me mobile app, and additional ZIP codes and procedures will be added soon. This tool is not intended to be a guarantee of your costs or benefits. Your actual costs and/or benefits may vary. When accessing the tool, please refer to the Terms and Conditions of Use and Why Your Costs May Vary sections for further information regarding cost estimates. Refer to your health plan coverage document for information regarding your specific benefits.

For a complete description of the UnitedHealth Premium® designation program, including details on the methodology used, geographic availability, program limitations and medical specialties participating, please visit myuhc.com®. *Some features may not be available for all employer plans. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health plan coverage provided by or through a UnitedHealthcare company. NurseLine℠ is for informational purposes only. Nurses cannot diagnose problems or recommend specific treatment and are not a substitute for your doctor's care. NurseLine services are not an insurance program and may be discontinued at any time.



We're here to help make things simpler for you.

We know that managing your health plan benefits and your health isn't always easy. That's why we have a team of people dedicated to helping you. From understanding your claims to estimating costs ahead of time, we're here to help. You may want to know:

- Is this treatment covered?
- How much will I have to pay for a test my doctor wants me to get?
- What does this charge mean on my bill? And why is it this amount?
- Can you help explain my benefits and what I need to do?
- If I need to find a new doctor, can you help me?

Contact us for help with a personal touch.

Phone:
Call the member number listed on your health plan ID card

Chat:
Log on to **myuhc.com®** and click the "Call or Chat" button.

DENTAL PLAN

The City of San Marcos' Dental Plan is administered through United HealthCare and provides you and your family with coverage for typical dental expenses, such as cleanings, X-rays, and fillings.

Dental Indemnity Plan

The Dental Indemnity Plan allows you the freedom to visit any dentist, without referrals, for all of your dental care. If you receive care from one of UHC preferred dentists, you will pay less for your care. If you choose a non-preferred dentist, your share of costs will generally be higher and you may need to file your own claims. For a list of UHC preferred dentists, go to www.myuhc.com or call 800-445-9090.

You will receive a dental ID card to use to receive dental services. When you visit the dentist, give the provider your ID card. Your dentist's office can verify your eligibility for benefits by calling UHC at 1-800-445-9090

Dental Plan Highlights

Plan Feature	Indemnity Dental Plan
Annual Deductible Individual Family	 $50 $150
Annual Benefit Maximum	$1,500
Preventive Services (Exams, routine cleanings, fluoride treatments, space maintainers)	100%
Basic Services (X-rays, fillings, sealants, denture repairs)	80%
Major Services (Crowns, inlays, onlays, bridges, dentures)	50%
Orthodontia	Not Covered

VISION PLAN

The City of San Marcos' Vision Plan promotes preventive care through regular eye exams and provides coverage for corrective materials, such as glasses, contact lenses and safety glasses. The Vision Plan is administered through Davis Vision.

Vision Coverage

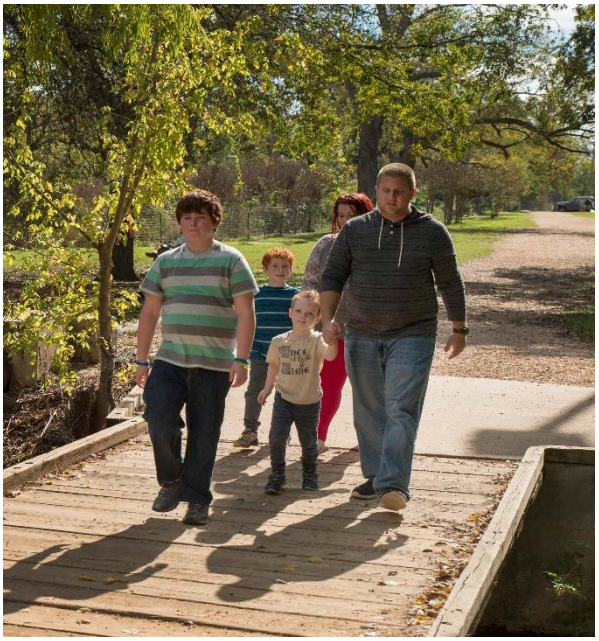
If you enroll in vision coverage, you can go to any eye care provider you choose for care. However, if you choose providers who are part of the Davis Vision network, you will receive a discount on services. To find a network provider, go to www.davisvision.com.

The Vision Plan is designed to cover eye care needs that are visually necessary. You have to pay extra if you choose certain cosmetic or elective eyewear, so be sure to ask your eye doctor what items are covered by the plan before you purchase materials.

Vision Plan Highlights – Premium, Basic and Safety Glasses Plan

	In-Network – Basic	In-Network – Premium	Out-of-Network	Safety Glasses Rider
Plan Feature	**You Pay**	**You Pay**	**Reimbursement up to the follow:**	
Eye Exam	$0 copay	$0 copay	$40	$0 copay
Prescription Glasses	$25 copay	$10 copay	$25	N/A
Single Lenses	$25 copay	$10 copay	$40	$10 copay
Bifocals – Lined	$25 copay	$10 copay	$60	$10 copay
Trifocals – Lined	$25 copay	$10 copay	$80	N/A
Frames	$0 copay	$0 copay	$50	$0 copay
Contacts	$25 copay	$10 copay	$105	N/A
Medically Necessary	$0 copay	$0 copay	$225	N/A
Contact Lens Exam (Fitting and Eval)	$0 copay	$0 copay	$0 copay	N/A
Benefit Frequency				
Eye Exam	Every 12 months	Every 12 months	Every 12 months	Every 12 months
Frames	Every 24 months	Every 24 months	Every 24 months	Every 24 months
Lenses	Every 12 months	Every 12 months	Every 12 months	Every 12 months
Contacts	Every 12 months	Every 12 months	Every 12 months	Every 12 months

LIFE INSURANCE



The City of San Marcos offers life insurance coverage to provide financial protection in the event you or your dependents die while you are still working. This coverage is administered through Voya.

Basic Life Insurance

The City of San Marcos automatically provides Basic Life Insurance for all eligible employees at no cost. Basic Life Insurance is a flat amount of $25,000. The benefit is paid to your beneficiaries in the event of your death.

IRS Rules about Basic Life Coverage

The City of San Marcos has adopted the TMRS Supplemental Death Benefit. This additional benefit provides a payment equal to your annual salary to your beneficiary. This amount is also included in the "imputed income" calculation for tax purposes. IRS regulations require that the value of life insurance benefits over $50,000 be reported as "imputed income," which is non-cash income that you receive from an employer-provided benefit. The value of any coverage that exceeds $50,000 will be reported to the IRS as imputed income on your W-2 form.

Supplemental Life Insurance

In addition to Basic Life Insurance, you may also purchase Supplemental Life Insurance for yourself, your spouse, and your dependent children. However, you may only elect coverage for your dependents if you enroll for Supplemental Life coverage for yourself. You pay for the cost of Supplemental Life Insurance on an after-tax basis through payroll deductions.

The combined coverage for Basic and Supplemental Life Insurance for yourself cannot exceed 5 times basic annual salary or $300,000. At initial enrollment, the Guaranteed Issue amounts are $150,000 for employee and $25,000 for spouse.

Supplemental Life Insurance Coverage

Coverage For	Coverage Available
Employee	$10,000 increments not to exceed 5 times basic annual salary or $300,000. $150,000 Guaranteed Issue if enrolled at initial eligibility.
Spouse	$5,000 increments up to $150,000, not to exceed 50% of Employee's elected supplemental life amount. $25,000 Guaranteed Issue if enrolled at initial eligibility.
Child(ren)	$1,000, $5,000 or $10,000 increments.

Beneficiary Designation

You must designate a beneficiary for Basic and Supplemental Life Insurance benefits when you enroll. Your "beneficiary" is the person(s) who will receive the benefits from your Life and AD&D coverage in the event of your death. You are always the beneficiary of any Dependent Life and AD&D Insurance you elect. You can change your beneficiaries at any time during the year. If you do not name a beneficiary, or if your beneficiary dies before you, your Life and AD&D benefits will be paid to your estate.

Benefits Reduce At Age 70

When you or a covered dependent reaches age 70, Basic and Supplemental Life Insurance benefits are reduced. For more information, refer to your Group Life Insurance booklet.

AD&D INSURANCE

The City of San Marcos offers Accidental Death and Dismemberment (AD&D) Insurance for you and your family to help with expenses in the event you or a covered dependent dies or becomes injured as a result of an accident. This coverage is administered through Voya.

Basic AD&D Insurance

The City of San Marcos automatically provides Basic AD&D Insurance for all eligible employees at no cost. Basic AD&D Insurance is a flat $25,000. The total amount of your group life and AD&D coverage cannot exceed 5 times your annual base earnings.

Supplemental AD&D Insurance

In addition to Basic AD&D Insurance, you may also purchase Supplemental AD&D Insurance for you. You pay for this coverage on a pre-tax basis through payroll deductions.

Beneficiary Designation

You must designate a beneficiary for Basic and Supplemental AD&D Insurance benefits when you enroll. Your "beneficiary" is the person(s) who will receive the benefits from your Life and AD&D coverage in the event of your death. You are always the beneficiary of any Dependent Life and AD&D Insurance you elect. You can change your beneficiaries at any time during the year. If you do not name a beneficiary, or if your beneficiary dies before you, your Life and AD&D benefits will be paid to your estate.

Supplemental AD&D Insurance Coverage

Coverage For	Coverage Available
Employee	$10,000 increments not to exceed 5 times basic annual salary or $300,000. $150,000 Guaranteed Issue if enrolled at initial eligibility

DISABILITY COVERAGE

The City of San Marcos offers a Long-Term Disability plan that you may purchase that works to keep all or part of your paycheck coming if you cannot work because of illness or injury. Disability benefits are administered through Voya.

Long-Term Disability

If you remain totally disabled and unable to work for more than 90 consecutive days, you may be eligible for Long-Term Disability (LTD) benefits. The LTD benefits replace up to 60% of your base pay, up to a maximum of $5,000 per month. Your monthly LTD benefit will be reduced by Social Security and any other disability income you are eligible to receive (such as Workers' Compensation).

When Are You Disabled?

To be considered totally disabled and eligible for LTD benefits, you must be approved by the insurance carrier and seeing a doctor regularly for treatment. In addition:

- Your doctor must certify that you are not able to do your job at the City of San Marcos, and
- You must have lost 20% or more of your pre-disability income due to your illness or injury.

FLEXIBLE SPENDING ACCOUNTS

The City of San Marcos allows you to contribute to one or both Flexible Spending Accounts (FSAs), which allow you to save taxes on certain out-of-pocket health care and dependent care expenses. The FSAs are administered by UHC.

How the FSAs Work

The City of San Marcos offers two types of FSAs:

- Health Care FSA
- Dependent Care FSA

If you elect to contribute to one or both of the FSAs, you choose an annual amount to be taken from each of your paychecks and deposited into your account throughout the year.

Your contributions are taken out of your paycheck before you pay taxes, so you save money. Then, when you have eligible health care or dependent care expenses, you can use the account to reimburse yourself, up to the amount you have elected to contribute to your account for the year.

With both accounts, the IRS requires you to use all of the money in your account by the end of the year or you lose it. This is called the "use it or lose it" rule. The City of San Marcos has an IRS extended grace period of 2 ½ months after the plan year ends.

Grace Period - Extension of Incurring Expense

You have 166 days into the next year to request reimbursement for Eligible Expenses incurred during the Plan year and those incurred during the first 2.5 months immediately following the end of the Plan year. If you have unused contributions in your account at the end of the current Plan year you can continue to incur expenses during the first 2.5 months immediately following the end of the Plan year and receive reimbursement for these expenses until such unused funds are depleted. All requests for reimbursement will be accepted and processed through 166 days into the next plan year. After 166 days into the next plan year, funds remaining in your account for the current Plan year will be forfeited.

HEALTH CARE FSA

You can use the Health Care FSA to pay for eligible out-of-pocket expenses that are not covered by another health plan. Examples include, but are not limited to:

- Medical, dental or prescription deductibles and coinsurance amounts
- Office visit or prescription copays
- Amounts you pay for certain over-the-counter items
- Eyeglasses, contacts, and other vision-related expenses not covered by the vision plan
- Orthodontia expenses not covered by the dental plan

For a complete list of eligible expenses, visit www.myuhc.com.

Annual Contribution Amount

You can contribute $100 to $2,600 per year to the Health Care FSA.

Over-the-Counter Medications

You must have a doctor's prescription to use the Health Care FSA to reimburse yourself for certain over-the-counter medications. Examples of medications that require you to submit a doctor's prescription include:

- Acid controllers, digestive aids, and stomach remedies
- Allergy and sinus medicines
- Anti-itch and insect bite remedies
- Cold sore remedies
- Cold, cough, and flu drugs
- Pain relief medications
- Respiratory treatments
- Sleep aids and sedatives

How the Debit Card Works

If you enroll in the Health Care FSA, you will receive one debit card in the mail. To request additional debit cards for your family members, please contact UHC.

You can use your debit card at certain places to pay for eligible expenses up-front, such as prescription drugs and office visit copays, without having to pay with cash and wait for a reimbursement. If you use your debit card at a health care provider's office or at a vendor that has the software in place to track eligible FSA expenses, you will not be required to submit a receipt. For a list of vendors that have this software, go to www.myuhc.com. You will have access to your annual election upon eligibility.

However, for most debit card transactions, you will need to submit your receipts as substantiation of your expense, so it is important to keep them.

If you choose not to use your debit card, you can always pay for your eligible expense and file a claim for reimbursement.

Dependent Care FSA

The Dependent Care FSA helps you afford day care for your children under age 13 or for a disabled dependent. The Dependent Care FSA is funded on a per pay period basis. There are some special rules for participating in this account:

- The day care expenses must be necessary so you can work.
- You can only be reimbursed for expenses incurred during the plan year.
- If you are married, your spouse must be employed, a full-time student at least five months during the plan year, or mentally or physically disabled and unable to provide care for himself or herself.

In some cases, a federal child-tax credit may save you more money than the Dependent Care FSA. You may want to consult a tax advisor to find which option is better for you.

Eligible Dependent Care Expenses

Generally, you may use the money in your Dependent Care FSA for care for:

- Your children under age 13 whom you claim as a dependent for tax purposes.
- Other dependents of any age who are mentally or physically disabled and whom you claim as a dependent for tax purposes (spouses and dependents age 13 and older must spend at least eight hours a day in your home if you are reimbursing yourself for services provided outside the home).

Some typical expenses that are eligible for reimbursement under the plan are:

- Licensed nursery school and day care centers for children
- Licensed day care centers for disabled dependents
- Services from a care provider over the age of 19 (inside or outside the home)
- Day camps and After-school care

For a complete list of eligible expenses, visit www.myuhc.com.

Annual Contribution Amount

You can contribute $100 to $5,000 per year to the Dependent Care FSA. If you are married and you and your spouse file separate tax returns, the maximum you can contribute is $2,500 each.

Important FSA Considerations (Health Care and Dependent Care)

- Any money left in your FSAs at the end of the plan year may not be rolled over to pay for future expenses in another plan year. Any unused funds will be forfeited, per IRS rules. **The City of San Marcos has an IRS extended grace period of 2 ½ months after the plan year ends.**
- For the Dependent Care FSA, you may only be reimbursed up to the amount in your account at the time you file a claim. If your eligible expenses are greater than the amount in your account, the unreimbursed amount will carry over and be reimbursed after your next deposit. (For the Health Care FSA, you can be reimbursed up to the full amount you have elected to contribute for the year — even if you have not yet contributed that much to your account.)
- The Health Care FSA and the Dependent Care FSA are separate accounts. You cannot use funds from one account to pay for expenses of the other. You also cannot transfer funds between the two accounts.
- If you use the Dependent Care FSA, you must provide your caregiver's Social Security number or tax ID when you file a claim for reimbursement.

RETIREMENT PROGRAMS

TEXAS MUNICIPAL RETIREMENT SYSTEM (TMRS)

Effective upon employment, all full time and part time employees authorized to work 20 hours or more (except temporary, seasonal and part time under 20 hours) are automatically enrolled with Texas Municipal Retirement System (TMRS). Each active employee contributes 7% of their salary to their account with a City matching credit of a 2:1 ratio, or $2.00 for every $1.00 deposited by the employee, with a 5 year vesting period.

Service Retirement Eligibility

- Age 60 with 5 years of service
- Any age with 20 years of service

For additional personal account information or to add other eligible service credit, visit the TMRS website at www.tmrs.org or contact customer service at 800.924.8677.

ICMA-RC

457 Deferred Compensation Plan

The ICMA-RC 457 Plan allows you to invest in your retirement and is a great way to supplement your TMRS retirement benefit. Taxes on your contribution are deferred until your assets are withdrawn. Also, there is not a 10% federal tax penalty on withdrawals, regardless of your age. This plan does have a loan provision, allowing members to borrow from their account.

Employees can enroll with as little as $10 and can contribute up to the current maximum of $18,000. Contributions are effective with the first pay of the month and can be changed at any time. Enroll online or access your current account at icmarc.org or use the free mobile app to manage your account on the go. Our Plan number is 302267.

Roth IRA

The Roth IRA provides another great opportunity to save for retirement. Contributions are made after taxes through payroll deduction up to the contribution limits of $5,500 or $6,500 if you are over the age of 50. This plan does have income limits, therefore you must qualify based on your household income. Withdrawals of earnings are tax-free if the account has been held for 5 years and you are age 59 ½ or older. Please contact ICMA-RC for more information.

OTHER BENEFITS

Employee Assistance Program (EAP)

You and your covered dependents have free access to the City of San Marcos Employee Assistance Program (EAP) provided by Alliance Work Partners. This confidential service offers free over-the-phone counseling any time, day or night, to help you with a variety of personal issues. The EAP also provides up to 5 free face-to-face counseling sessions for both you and your eligible dependents. Counselors can help with concerns about things like:

- Emotional well-being and mental health
- Relationships and parenting
- Addiction and recovery
- Marital and family problems
- Legal and financial issues

To contact the EAP, call 800-343-3822 24 hours a day, seven days a week, to talk to a professional counselor. You can also get more information online at www.awpnow.com.

2018 MONTHLY INSURANCE RATES

MEDICAL

Rate Tier	Total Rate	Employer	Employee	Employee (non-well rate)
Employee Only	$613.00	$557.00	$56.00	$106.00
Employee-Spouse	$1,292.00	$1,017.00	$275.00	$325.00
Employee-Child(ren)	$1,258.50	$994.50	$264.00	$314.00
Employee-Family	$1,933.00	$1,427.50	$505.50	$555.50

DENTAL

Rate Tier	Total Rate	Employer	Employee
Employee Only	$30.00	$30.00	$0.00
Employee-Spouse	$71.50	$50.50	$21.00
Employee-Child(ren)	$62.50	$46.00	$16.50
Employee-Family	$90.50	$60.00	$30.50

VISION

Rate Tier	Basic	Premium	Safety Glasses
Employee Only	$6.52	$14.22	$4.71
Employee-Spouse	$9.06	$19.92	$4.71
Employee-Child(ren)	$9.38	$20.62	$4.71
Employee-Family	$12.94	$28.44	$4.71

Supplemental Life Insurance Rate and Premium Calculator

The cost is calculated based on the age of the employee or spouse at the start of the plan's current policy year.

Employee and Spouse Supplemental Life Insurance Rates

Age	Monthly Cost per $1,000 of Coverage
Under 30	$0.050
30-34	$0.060
35-39	$0.070
40-44	$0.120
45-49	$0.180
50-54	$0.330
55-59	$0.530
60-64	$0.840
65-69	$1.320
70 +	$1.650

Supplemental Accidental Death and Dismemberment (AD&D) Insurance Rates

Coverage type	Monthly Cost per $1,000 of Coverage
Employee Supplemental AD&D	$0.035

Dependent Children Life Insurance Rates

Coverage Levels	Monthly Cost
$1,000	$0.150
$5,000	$0.750
$10,000	$1.500

Follow the steps below to calculate the premium based on the amount of insurance you plan to elect.

Supplemental Life and AD&D Insurance	For You	For Your Spouse	For Your Children
Step 1: Select the amount of insurance you want	$	$	$
Step 2: Divide this number by $1,000	$	$	N/A
Step 3: Enter the rate from the table(s) above	$	$	(C) $
Step 4: Multiply Step #2 by Step #3	(A) $	(B) $	N/A
Step 5: Add **(A)**, **(B)**, and **(C)** for the Total Monthly Supplemental Life Insurance Premium	$		
Step 6: Select the amount of insurance you want	$	N/A	N/A
Step 7: Divide this number by $1,000	$	N/A	N/A
Step 8: Enter the rate from the table(s) above	$	N/A	N/A
Step 9: Multiply Step #7 by Step #8	(A) $	N/A	N/A
Step 10: Add **(A)** for the Total Monthly AD&D Premium	$	N/A	N/A

Total Monthly Premium - Add Step 5 and Step 10	$

Long Term Disability Insurance Rate and Premium Calculator

The cost is calculated based on the age of the employee or spouse at the start of the plan's current policy year.

Age	Your Contribution per $100 of Salary Benefit
Under 25	$0.18
25-29	$0.27
30-34	$0.41
35-39	$0.55
40-44	$0.77
45-49	$1.06
50-54	$1.59
55-59	$2.05
60-64	$2.16
65 and over	$1.49

Monthly Disability Income Coverage Table		
Enter the elected benefit amount.	$	(a)
Enter Long Term Disability Income Rate based on your age	$	(b)
Multiply **(a)** times **(b)**	$	(c)
Divide **(c)** by 100. This figure will be the monthly cost.	$	(d)
Multiply **(d)** times 12	$	(e)
Divide **(e)** by 24 pay periods. The final figure will be the cost per pay period.	$	

HEALTH COVERAGE NOTICES FOR THE CITY OF SAN MARCOS

This brochure contains legal notices for participants in group health plan(s) sponsored by the City of San Marcos. The notices included in this guide are:

- ***Health Insurance Marketplace Coverage Options and Your Health Coverage*** *that describes the Health Insurance Marketplace and eligibility and tax credit information.*
- ***Notice of Privacy Practices*** *that explains how the health care plan(s) protect your personal medical information.*
- ***Medicare Part D Notice*** *that provides information about how your current prescription drug coverage under the health care plan(s) is affected—and your options for coverage—when you become eligible for Medicare.*
- ***COBRA Rights Notice*** *that explains when you and your family may be able to temporarily continue coverage under the health care plan(s) if coverage would otherwise end for you.*
- ***Wellness Program and Reasonable Alternatives Notice*** *that informs employees of what information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential, as well as options for those who have a medical condition that makes wellness program participation difficult.*
- ***Expanded Coverage for Women's Preventive Care*** *that explains how the health care plan(s) cover(s) women's preventive care, including contraceptives, under the Affordable Care Act.*
- ***Notice of "Grandfathered Health Plan" Status*** *that describes how the health care plan(s)/ mental health and substance abuse are classified under the Affordable Care Act and why.*
- ***60-Day Special Enrollment Period*** *that describes a special 60-day timeframe to elect or discontinue coverage.*
- ***Notice of Special Enrollment Rights*** *that explains when you can enroll in the health care plan(s) due to special circumstances.*
- ***Newborn & Mothers Health Protection Notice*** *that describes federal laws that govern benefits for hospital stays for mothers following the birth of child.*
- ***Women's Health and Cancer Rights Act*** *that summarizes the benefits available under your medical plan if you have had or are going to have a mastectomy.*

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

Since key parts of the health care law took effect in 2014, there is another way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Typically, you can enroll in a Marketplace health plan during the Marketplace's annual Open Enrollment period or if you experience a qualifying life event.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.56% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources at 512-393-8064.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

CITY OF SAN MARCOS NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Our Company's Pledge to You

This notice is intended to inform you of the privacy practices followed by the *City of San Marcos Health Plan* (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on *January 1, 2018*.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. *The City of San Marcos* requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or Required by Law. We may also use or disclose your protected health information without your written authorization for other reasons as *permitted* by law. We are *permitted* by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when *required* by law, for example, in order to prevent serious harm to you or others.

Pursuant to Your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If

you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of the *City of San Marcos* for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:
Human Resources
City of San Marcos
630 East Hopkins, San Marcos, Texas 78666
512-393-8060 & benefits@sanmarcostx.gov

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

Medicare Part D Prescription Drug Notice

IMPORTANT NOTICE FROM CITY OF SAN MARCOS ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of San Marcos and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. City of San Marcos has determined that the prescription drug coverage offered by the City of San Marcos plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of San Marcos coverage will be affected. If you do decide to join a Medicare drug plan and drop your current City of San Marcos coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the City of San Marcos and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of San Marcos changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare Prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: September, 2017

Name of Entity/Sender: City of San Marcos

Contact/Office: Human Resources Department

Address: 630 East Hopkins, San Marcos, Texas 78666

Phone Number: 512-393-8064

COBRA RIGHTS NOTICE

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the Plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 31 days after the qualifying event occurs. You must provide this notice to: Human Resources.

How Is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.
There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Date: September 2017
Name of Entity/Sender: City of San Marcos
Contact/Office: Human Resources Department
Address: 630 East Hopkins, San Marcos, Texas 78666
Phone Number: 512-393-8060

OTHER NOTICES

Wellness Program and Reasonable Alternatives Notice

San Marcos Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a biometric screening, which will include a blood test for Cholesterol, HDL, TC/ HDL ratio, glucose, LDL cholesterol, triglycerides and A1C. You are not required to participate in the blood test or other medical examinations.

Although you are not required to participate in the biometric screening, only employees who do so will receive medical premium reduction. If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable alternative standard.

The results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and City of San Marcos may use aggregate information it collects to design a program based on identified health risks in the workplace, The City of San Marcos will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are a registered nurse or physician in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

Reasonable Alternatives

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you think you might be unable to meet a standard for a reward under the City of San Marcos Wellness Program, you might qualify for an opportunity to earn the same reward by different means. Contact Human Resources at 512-393-8060 and we will work with you (and if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact City of San Marcos, Human Resources Department at 512-393-8060.

Expanded Coverage for Women's Preventive Care

Under the Affordable Care Act, City of San Marcos provides female plan participants with expanded access to recommended in-network preventive services, including contraceptives, without cost sharing.
Additional women's preventive services that will be covered without cost sharing requirements include:

- Well-woman visits
- Gestational diabetes screening
- HPV DNA testing
- STI counseling, and HIV screening and counseling
- Contraception and contraceptive counseling
- Breastfeeding support, supplies, and counseling
- Domestic violence screening

For a description of what these items include, visit https://www.healthcare.gov/preventive-care-women/.

Notice of "Grandfathered Health Plan" Status

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 512-393-8064. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272, or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

60-Day Special Enrollment Period

In addition to the qualifying events listed in the enrollment guide and this document, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

- You or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

Notice of Special Enrollment Rights

If you decline enrollment in medical coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in the City of San Marcos medical coverage if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment no more than 30 days after your or your dependent's other coverage ends (or after the employer stops contributing to the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you can enroll yourself and your dependents in the City of San Marcos medical coverage as long as you request enrollment by contacting the benefits manager no more than 30 days after the marriage, birth, adoption or placement for adoption. For more information, contact City of San Marcos, Human Resources Department at 512-393-8064.

Newborn & Mothers Health Protection Notice

For maternity hospital stays, in accordance with federal law, the Plan does not restrict benefits, for any hospital length of stay in connection with childbirth for the mother or newborn child, to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultations with the attending physician and the patient, for:

- All states of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact the City of San Marcos, Human Resources Department at 512-393-8064.

NOTES

IMPORTANT CONTACTS

Resource	Phone Number	Website/E-mail
City of San Marcos Benefits	512-393-8060	benefits@sanmarcostx.gov
UHC Medical	844-269-5757	www.myuhc.com Advocate4Me@uhc.com
UHC Pharmacy	888-290-5416	www.myuhc.com
UHC Dental	800-445-9000	www.myuhc.com
Davis Vision	877-923-2847	www.davisvision.com
UHC Flexible Spending Accounts	866-755-2648	www.myuhc.com
United Behavioral Health	844-269-5757	www.liveandworkwell.com
Voya Life Insurance	888-238-4840	www.voya.com www.claimscenter.voya.com
Voya Disability Coverage	888-305-0602	www.voya.com www.claimscenter.voya.com
Alliance Work Partners Employee Assistance Program	800-343-3822	www.awpnow.com
ICMA	800-669-7400	www.icmarc.org
TMRS	800-924-8677	www.tmrs.org